BRAIN INJURY
SOCIAL HISTORY

Instructions: This information is necessary for a complete assessment, so that the right services can be provided. Please answer all questions as completely as possible.

IDENTIFYING INFORMATION:

1. Name: _____ Age:_____Race: _____
   Birth date: _____ Soc. Sec. #: _____ Sex: _____

   Drivers License #: _____
   Current Day and/or Residential Placement: _____

   Home Address:_____Home Phone:_____

   Medicaid # (if applicable):_____
   Any medical diagnosis (if known):_____
   Any mental health diagnosis (if known):_____

   Normal pregnancy/delivery? Yes___No_____ If no, please explain _____
   _____
   _____
   How and when did injury occur? _____
   _____
   _____

PRESENTING PROBLEM:

2. What are your present emotional, behavioral, or medical problems, or problems that led to this
   referrals?_____
   _____
   What is being done about this problem? _____
   _____

3. Do you live alone or with others? If you live with someone, who do you live with? (Please include relationship.) _____
   _____

4. Have there been any major family incidents or tragedies (death, divorce, rape, imprisonment, etc.), which may have affected you? If so explain and tell when: _____

_____

_____

_____

FAMILY HISTORY:

5. Father's Name: _____ Age: _____ Race:_____

Birth date: _____ Deceased: _____ If so, date: _____

Cause of death: _____

List any medical, mental health, or substance abuse family history, if any, of father or father's family: _____

_____

_____

6. Mother's Name: _____ Age: _____ Race:_____

Birth date: _____ Deceased: _____ If so, date: _____

Cause of death: _____

List any medical, mental health, or substance abuse family history, if any, of mother or mother's family: _____

_____

_____

7. Brothers and sisters:

Name	Birth date	Sex	Medical/Mental Health

8. Spouse's Name: _____ Age: _____ Race: _____

Birth date: _____ Deceased: _____ If so, date: _____

Cause of death: _____

List any medical, mental health, or substance abuse family history, if any, of spouse or spouse's family: _____

_____

_____

9. What skills did you have to relearn after injury? _____

_____

_____

10. Are vaccinations current? _____

PRE-BRAIN INJURY:

11. Check any of the characteristics listed below, which applied to you as a child growing up:

	Shy or timid		Very active, into things more than others
	Withdrawn		Sleep disorder
	Bed wetting		Restless
	Cry easily or often		Often hit, hurt, or was aggressive towards other children
	Excessive anger, rage		Unusual fears
	More interested in things than people		Rocking
	Daredevil behaviors		Head banging
	Less active		Strange thoughts
	Fought constantly		Difficult to control
	Excitable, impulsive		Destructive
	Quarrelsome		Disliked being touched
	Distractible, poor attention span		Loner
	Problems making and keeping friends		Feelings easily hurt
	Denied mistakes and blamed others		Basically an unhappy child
	Passive		Stole things from others
	Cruel to pets or animals		Often injured self

12. Have you had previous emotional illness, which required treatment? If so, briefly describe problems and symptoms, location, and date of treatment: _____

_____

_____

13. Have you ever been arrested? If so, briefly describe charge, circumstances, what happened, and dates. Have you been in jail or prison? _____

_____

_____

MEDICAL HISTORY:

14. List any major illnesses, injuries, convulsions, etc., and age these took place: _____

_____

_____

_____

List lifetime history of hospitalizations:

Reason for Hospitalization	Date	Location

15. Have you had any vision problems? _____ If so, were glasses prescribed? _____
If so, when? _____ Date of last vision check: _____
16. Do you have a known hearing loss? _____ When was hearing last check? _____
17. Have you had problems with alcohol or drug dependence? Briefly describe: _____

_____

_____

_____

EMERGENCY CONTACTS:

Physician:		Phone:	
Address:			
Dentist:		Phone:	
Address:			
Responsible Party:		Phone:	
Address:			
Guardian/ Conservator		Phone	
Address:			

EDUCATIONAL HISTORY:

18. At what age did you begin school? _____
19. How many grades were completed? _____
20. Were any grades repeated? If so, why? _____
21. Which grades, if any, involved special education? _____
22. Highest grade achieved?

Degrees or Diploma	Date

VOCATIONAL HISTORY:

23. List all past:

Vocational Placements or Employment	Date

24. Have you had work related problems? _____ Reliable? _____
Special skills or success? _____
Problems with employers or other employees? _____ Explain: _____
_____
_____

PRESENT STATUS:

25. List current medications:

Type	Amount	Reason Prescribed	By Whom

26. List any other special behavioral problems: _____
_____
_____

27. List any allergies: _____

_____

_____

SELF HELP SKILLS

28. Check appropriate boxes:

Services/Help Do you receive help with:	Yes	No	Needs No Help or Supervision	Needs Some Help or Supervision	Needs More Help or Supervision	Needs Total Help and Supervision
Personal Care Assistance (Bathing, dressing, getting out of bed, toileting, and eating)						
Housekeeping (Laundry, cleaning, meals, etc.)						
Transportation						
Shopping/Errands						
Personal Finances (Money management)						
Services from Health Professional (RN, Therapist, etc.)						
Adult Day Care						
Home Delivered Meals (Formal Only)						
Any Other Kind of Help						

29. If help is needed, who provides assistance? _____

_____

30. If that person is unavailable, is there a backup? _____

_____

CURRENT SOCIAL ADJUSTMENT

31. Do you have friends? (Few? Any at all? A leader? A follower? Takes part freely in social activities? Lead a lonely life? Prefer older or younger friends? Seek or avoid opposite sex?) Briefly describe? _____

_____

_____

Form completed by: _____

Relationship to applicant: _____

Date: _____